



Patient Information

Thank you so much for choosing Oconee Audiology for your hearing healthcare. We appreciate your business and look forward to working with you. Please complete the following information so that we may better serve you.

Name: _____ Date of Birth: _____ Date: _____

Mailing Address: Street _____ City _____ State _____ Zip _____

Telephone Number: _____ Email: _____

Insurance Carrier: _____ Primary Care Doctor: _____

Where is your doctor located? _____ May we send your doctor a report? Yes No

How did you hear about us? _____

What is the main reason you are visiting us today? _____

Will this be the first time you have had a hearing test? Yes No

If no, when were you last tested and where? _____

MEDICAL HISTORY: Please check mark next to the symptoms you have had in the past or currently have:

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Noise Exposure |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Family history of hearing loss | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sudden decrease in hearing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tinnitus (ringing/noises in the ears) |

Other: Please describe: _____

Are you taking blood thinners? Yes No

Do you hear better in one ear? Yes: the right side Yes: The left side No: both ears are the same

Medicines you are currently taking: _____

Is there any other information that you consider relevant to your visit with us today? _____

AUTHORIZATION: I agree to allow Oconee Audiology to send me offers and/or promotions via mail and/or email to keep me updated on the latest and most advanced hearing technologies available, as well as any upcoming scheduled marketing events.

Signature

Date